

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5035

CERTIFICATE OF DEATH

05013

Reg. Dist. No. 94

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Charlestown</u>		LENGTH OF STAY (in this place) <u>33 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Charlestown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Harry M Blackwell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 21, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 5, 1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comm Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Blackwell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Joseph R Llanos North East, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332x IMMEDIATE CAUSE (A) <u>Rt. cerebral thrombosis with left Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 March 1956</u> , to <u>31 May 1956</u> , that I last saw the deceased alive on <u>8 May 1956</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Klaus H. Henschel</u>		M.D.		ADDRESS (Street, city, town, state) <u>North East, Md</u>		DATE SIGNED <u>21 May '56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial 1</u>		DATE THEREOF <u>May 24 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Charlestown</u>		LOCATION (City, town, or county) (State) <u>Charlestown, Cecil, Md</u>	
24. REC'D BY REGISTRAR DATE <u>5-24-56</u>		REGISTRAR'S SIGNATURE <u>Sarah E. Rothman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Llanos</u> ADDRESS <u>North East, Maryland</u>			

CERTIFICATE OF DEATH

14

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. E.

MAY 29 1956

RECEIVED

2-24-56 2-24-56

5936

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Elkton-R.D.</u>	LENGTH OF STAY (in this place) <u>16 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Near Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		STREET ADDRESS (If rural give location) <u>ELKTON, R.D. 1.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(Type or Print) <u>First (Middle) (Last)</u> <u>Mabel Rebecca Jordan Bowman</u>		<u>May 30 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Mar 17 1891</u>
9. AGE last birthday: <u>65</u> yrs.		10. CITIZENSHIP: <u>U.S.A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>	
13. FATHER'S NAME: <u>Frank Jordan</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Alice Irwin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>No</u>		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <u>Henry C. Leak, Ason</u>		<u>Elkton, R.D. 1 Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) DUE TO <u>Cerebral Hemorrhage</u>			<u>Dec 1-55</u>
ANTECEDENT CAUSE (S) DUE TO <u>with paralysis</u>			<u>May 29-56</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension & Atherosclerosis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 1st 1955</u> to <u>May 30 1956</u> that I last saw the deceased alive on <u>May 29 1956</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>H. J. M. Smith</u>		DATE SIGNED <u>Elkton Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 2/56</u>	
NAME OF CEMETERY OR CREMATORY <u>ELKTON</u>		LOCATION (City, town, or county) (State) <u>ELKTON, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 2</u>		REGISTRAR'S SIGNATURE <u>H. J. M. Smith</u>	
24. FUNERAL DIRECTOR <u>Henry C. Leak</u>		ADDRESS <u>Elkton, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 4 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05015

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>visit</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Union Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.J.</u> b. COUNTY <u>Essex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Orange</u> d. STREET ADDRESS <u>40 Sussex</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
---	--	---	--

3. NAME OF DECEASED (Type or print) <u>Thomas</u> <u>Baynard</u> <u>Brady</u> First Middle Last				4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1956</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-1905</u>		9. AGE (In years last birthday) <u>51</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Any kind of work</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B. Brady</u>						14. MOTHER'S MAIDEN NAME <u>No Information</u>					

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>155-14-7564</u>		17. INFORMANT <u>Sylvania Brady</u>		Address <u>40 Sussex Ave E. Orange</u>	
---	--	--	--	---	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>N.J.</u>	
---	--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>5-30-56</u>		
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bohemia Manor Cem.</u>		22d. LOCATION (City, lawn, or county) <u>Bohemia Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw R Bell, Wilms, Wela</u>				24a. REC'D BY REGISTRAR <u>6/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>FR Trauer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CITY		8. COUNTY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF EXAMINER		15. DATE OF EXAMINATION	
16. SIGNATURE OF ATTENDING PHYSICIAN		17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY		19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF CLERK	

BUREAU V-5

JUN 4 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05016 92

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellettsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.C. Union Hospital</u>		d. STREET ADDRESS <u>Betterton</u> 14 X - 2	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>ROBERT</u> Middle <u>BRIE</u> Last <u>E</u>		4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-1931</u>
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elect. Repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11. BIRTHPLACE (State or foreign country) <u>Betterton Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Samuel Brie</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bell Story</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes - Korean</u>		16. SOCIAL SECURITY NO. <u>220-28-419</u>	
17. INFORMANT <u>Mrs. H. L. Owens, Betterton Ind.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> 916.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Oil Tank exploded at Kent Oil Co. Yard</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-18-56</u> <u>8</u> o. m. <u>8</u> p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Kent Oil Co.</u>	20f. City or town <u>Galena</u> (County) <u>Kent</u> (State) <u>Ind.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>RC Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	22b. DATE THEREOF <u>5-18-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND, CEMTY</u>	22d. LOCATION (City, town, or county) <u>STILL POND, MD.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>Still Pond, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>5/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>E. Robney Shager</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

MAY 21 1956

RECEIVED

Reg. Dist. No. 96

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Donnerstag			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 19-56-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last DAUGHERTY, JR.				4. DATE OF DEATH Month May Day 1 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-3-07	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months 48	IF UNDER 24 HRS. Days 48	Hours 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Daugherty Sr.				14. MOTHER'S MAIDEN NAME Mary Somers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 2151 26 549		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Portal cirrhosis upper gastro-intestinal DUE TO (c) Hemorrhage due to bleeding esophageal varices						INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 1 year 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28 , 19 56 , to May 1 , 19 56 , that I caused the deceased to die SA , and that death occurred at 6:30a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, Perry Point, Md. 5-1-56							
ACTUAL SIGNATURE WM. M. HARRIS		PHYSICIAN'S NAME (Type) WM. M. HARRIS Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-1-56		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) Crisfield, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons Funeral Home, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 5-1-56		24b. REGISTRAR'S SIGNATURE James E. Daugherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

MAY 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05018

Reg. Dist. No.

5019

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b All Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 393 W. Main St.				d. STREET ADDRESS 393 W. Main St.			
3. NAME OF DECEASED (Type or print) Annie May First Dick Middle Last				4. DATE OF DEATH Month 5 Day 12 Year 1956			
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-1871		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Foracre				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Melrose Short, 393 W. Main St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-12-56	
EXAMINER'S NAME (Type) R. C. Dodson, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-56		22c. NAME OF CEMETERY OR CREMATORY New Catholic		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Huppert				24a. REC'D BY REGISTRAR DATE 5/15/56		24b. REGISTRAR'S SIGNATURE FR Frazer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 17 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville Rural		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Perryville Rural	
3. NAME OF DECEASED (Type or print) First Florence Middle Mary Last Downey		4. DATE OF DEATH Month May Day 13 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1887
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Lee		14. MOTHER'S MAIDEN NAME Emma Brousius	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Lewis A. Wright, Perryville, R.D.	
17. INFORMANT Mrs. Lewis A. Wright, Perryville, R.D.		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Diabetes INTERVAL BETWEEN ONSET AND DEATH 7 days 5 yrs 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1956 , to May 13, 1956 , that I last saw the deceased alive on May 12, 1956 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE [Signature] M.D. B. F. Woods, Jr., M.D. ADDRESS (Street, city or town, state) Perryville, Md. DATE SIGNED 5-14-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-56	
22c. NAME OF CEMETERY OR CREMATORY Sharp's Cemetery		22d. LOCATION (City, town, or county) (State) Fair Hill, Cecil Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		24a. REC'D BY REGISTRAR DATE 5-15-56	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun c. LENGTH OF STAY IN 1b all life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) West Main St.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun d. STREET ADDRESS West Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nepper First James Middle Edwards Last				4. DATE OF DEATH Month 5 Day 21 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Feb. 2 1872		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lab.		10b. KIND OF BUSINESS OR INDUSTRY Butcher shop		11. BIRTHPLACE (State or foreign country) Lancaster Co. Pa.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James Edwards			
14. MOTHER'S MAIDEN NAME Lavinia Coulson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Helen Plummer, Rising Sun, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 331x DUE TO (c) 331x DUE TO (c) 331x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>R.C. Dodson</i>				DATE SIGNED 5-22-56			
EXAMINER'S NAME (Type) R.C. Dodson				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-56		22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery			
22d. LOCATION (City, town, or county) Rising Sun Cecil Md.		23. FUNERAL DIRECTOR'S SIGNATURE <i>J.E. Tyson</i>					
ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR May 23-56		24b. REGISTRAR'S SIGNATURE <i>L.M.R. Rithington</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the instructions on the back of this certificate. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAY 24 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		June 3, 1956		Home	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner		Signature of Physician	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Residence		Date of Birth		Date of Death		Time of Death		Time of Examination		Time of Signature	
123 Main St.		Jan 1, 1911		June 3, 1956		10:00 AM		11:00 AM		12:00 PM	
City		County		State		Country		District		Division	
Baltimore		Baltimore		Maryland		USA		District 1		Division 1	
Hospital		Physician		Nurse		Attending Physician		Medical Director		Chief of Staff	
None		Dr. Smith		Mrs. Jones		Dr. Brown		Dr. White		Dr. Black	
Funeral Home		Burial Place		Crematorium		Interment		Disposition of Body		Disposition of Organs	
ABC Funeral Home		Catholic Cemetery		None		Buried		None		None	
Remarks		Remarks		Remarks		Remarks		Remarks		Remarks	
None		None		None		None		None		None	

BUREAU V. S.

JUN 4 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 96

5941

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2227 W. Hobart Street			
3. NAME OF DECEASED (Type or print) First Henry Middle (NMI) Last Greenberg				4. DATE OF DEATH Month May Day 12 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-94	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Roumania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Samuel Greenberg			
14. MOTHER'S MAIDEN NAME Sarah Goldenberg				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI			
16. SOCIAL SECURITY NO. Unk.				17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved 420.0 DUE TO Arteriosclerotic heart disease, with myocardial fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis, general, severe							INTERVAL BETWEEN ONSET AND DEATH 6 - 7 Days Unk. Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 27 , 19 56 , to May 12 , 19 56 , and that death occurred at Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Joseph Gruberger M.D. VA Hospital, Perry Point, Md. 5-13-56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D., Acting Dir., Professional Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-13-56		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gruberger				ADDRESS		24a. REC'D BY REGISTRAR DATE 5-13-56	
24b. REGISTRAR'S SIGNATURE Irene E. Doughty							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		1955-12-25	
Age		In Days	
65		180	
Sex		Race	
Male		White	
Marital Status		Occupation	
Married		Teacher	
Place of Birth		Usual Residence	
Baltimore, Md		Baltimore, Md	
Cause of Death		Immediate Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Site of Death		Place of Death	
Home		Home	
Physician		Hospital	
Dr. Smith		St. Mary's Hospital	
Manner of Death		Certification	
Natural		Physician's Signature	
		Date of Certification	
		1956-01-05	

BUREAU V. S.

RECEIVED

MAY 15 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil 5942 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural c. LENGTH OF STAY IN lb 15 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Dennis Middle Hamilton Last		4. DATE OF DEATH Month 5 Day 12 Year 1956	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1911
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Chrysler Plant	
11. BIRTHPLACE (State or foreign country) Beaver, Ken.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sie Hamilton		14. MOTHER'S MAIDEN NAME Dolly Pope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 200-0307278	
17. INFORMANT Stella Hamilton, Rising Sun, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-12-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-56	
22c. NAME OF CEMETERY OR CREMATORY New Bridge Bapt. Cem.		22d. LOCATION (City, town, or county) Coloma, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas E. Mullen</i>		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR <i>May 14 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Don Northington</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED

AGE

SEX

DATE

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

RESIDENT

AGE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

DECEASED

BUREAU V. S.

MAY 15 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home, and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05024

5043

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Rural		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Rural	
3. NAME OF DECEASED (Type or print) Woodrow Reo Hardiman		f. STREET ADDRESS	
4. DATE OF DEATH Month 5 Day 12 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1919
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Allegany, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Hardiman		14. MOTHER'S MAIDEN NAME Mary Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.2		16. SOCIAL SECURITY NO. 225-14-8010	
17. INFORMANT Catherine Hardiman, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed head and fracture of right clavicle DUE TO abrasions of legs and hand. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car turned over and landed on his head.	
20c. TIME OF INJURY Month, Day, Year 5 12 1956 Hour 9:15 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Scotts Creek Road		20f. (City or town) Fair Hill (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-12-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-56	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) Elkton Rural, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Lippin		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR 5/15/56		24b. REGISTRAR'S SIGNATURE J.H. Tragan	

500

BUREAU V. 3

MAY 17 1955

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, together with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director, and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05025

Reg. Dist. No. 97

Item 18 Film GL98 5-28-56 ams

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge c. LENGTH OF STAY IN lb 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manor Heights, Port Deposit, Md. d. STREET ADDRESS 207 Cl Laffey Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle (N) Last HOLMES		4. DATE OF DEATH Month MAY Day 16 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-56
9. AGE (In years last birthday) yrs. 22		IF UNDER 1 YEAR Months 2 Days 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Bainbridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Anderson HOLMES		14. MOTHER'S MAIDEN NAME Mildred Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Navy Records		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNDETERMINED DUE TO 795.5 (b) (Could not make diagnosis from autopsy) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DODSON EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-56	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson for Perryville, Md.		24a. REC'D BY REGISTRAR DATE 5-16-56	
24b. REGISTRAR'S SIGNATURE Dorothy B. Bramble			

2051323414

BUREAU V. S.

MAY 18 1956

RECEIVED

5045

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1145 Avenue B			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle QUINTER Last HOLSOPPLE				4. DATE OF DEATH Month May Day 10 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1900	
9. AGE (In years lost birthday) yrs. 55		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Psychologist				10b. KIND OF BUSINESS OR INDUSTRY Psychology		11. BIRTHPLACE (State or foreign country) Parkerford, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank F. Holsopple				14. MOTHER'S MAIDEN NAME Grace Quinter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I - WW II		17. INFORMANT Mrs. Nell Scott Holsopple, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 10 , 19 56 , to May 10 , 19 56 , that I last saw the deceased alive on May 9 , 19 56 , and that death occurred at 11:45 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE E. P. Brannon M.D. V.A. Hospital, Perry Point, Md.				5-11-56			
PHYSICIAN'S NAME (Type) E. P. BRANNON				Manager			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5-14-56		22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE May 11 - 1956		24b. REGISTRAR'S SIGNATURE Irvin E. Dougherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Street of Baltimore

House No. of Baltimore

Age of Deceased

Sex of Deceased

Color of Deceased

Marital Status of Deceased

Occupation of Deceased

Cause of Death

Time of Death

Place of Death

Signature of Physician

Signature of Registrar

Date of Death

BUREAU V. S.

MAY 14 1936

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05027

5920 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ELKTON</u>		<u>12 DAYS</u>		TOWN <u>CHILDS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>UNION HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED				4. DATE OF DEATH			
(Type or Print)		(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
<u>Sarah</u>				<u>Kinder</u>	<u>May</u>	<u>12</u>	<u>1956</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>4-13-1880</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>HOUSEWIFE</u>					<u>VIRGINIA</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WINTON HESTER</u>				<u>MARY HANKLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>none</u>				<u>none</u>		<u>Robert C White, C. Childs</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<u>Myocardial infarct</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>myocardial infarct</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Branchial-cyst</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 13, 1955</u> to <u>May 12, 1956</u> , that I last saw the deceased alive on <u>May 12, 1956</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. S. Specker</u> M.D.				ADDRESS (Street, city, town, state) <u>Elkton Rd Childs</u> DATE SIGNED <u>May 14, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-14-56</u>		<u>Union</u>		<u>Elkton Rd Childs</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>5/14/56</u>		<u>J. B. Trager</u>		<u>Joseph R. Trager</u>		<u>Elkton Rd Childs</u>	

CERTIFICATE OF DEATH

5980

AND DATE OF

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

BUREAU V

MAY 15 19

RECEIVED

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/SS

NEW JERSEY STATE DEPARTMENT OF HEALTH - BUREAU OF 3021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO INFORMATION

DEATH AT HOSPITAL

BUREAU V. 2

MAY 29 1956

RECEIVED

5022

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkhon</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) <u>Union Hosp. D.O.A.</u>		d. STREET ADDRESS <u>Chesapeake City Biddle</u>	
3. NAME OF DECEASED (Type and print) <u>Richard</u> First <u>Lockwood</u> Middle <u>LOLLER</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1918</u>
9. AGE (In years last birthday) <u>37</u> yrf.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Die Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Check tools</u>	
11. BIRTHPLACE (State or foreign country) <u>Earville Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James D Loller</u>		14. MOTHER'S MAIDEN NAME <u>Emma E Craig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-12-3353</u>	
17. INFORMANT <u>Mrs Richard L Loller</u> Address <u>Chesapeake City Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause <u>fractured skull</u> for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>fractured skull</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lightning fire at Kent Oil Co. Galena, Ind.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-18-56</u> Hour <u>8</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Kent Oil Co</u>	20f. City or town (County) (State) <u>Galena Cecil Ind</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>RC Dodson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>RC Dodson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>JOHN TOWN - CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL EARLEVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward E. Miller</u> ADDRESS <u>Millington Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>5/24/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>FR Frazee</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the day after death, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY		STATE	

BUREAU V. S.

MAY 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05030

5023 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) ELKTON		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) North East (Rural)		#1x	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location)		1	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) James F Mearns				4. DATE OF DEATH (Month) (Day) (Year) May 10 1956			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Sept. 5 1885	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Miller Mearns				14. MOTHER'S MAIDEN NAME Hannah Elizabeth Crothers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. 214-18-7314		17. INFORMANT & ADDRESS Mrs James F Mearns			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
610X IMMEDIATE CAUSE (A) Urinary Tract Infection				INTERVAL BETWEEN ONSET AND DEATH April 21-56			
ANTECEDENT CAUSE(S) DUE TO (B) Benign prostatic hyperplasia							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis, generalized.							
19a. DATE OF OPERATION April 10, 1956		19b. MAJOR FINDINGS OF OPERATION Benign prostatic hyperplasia		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 5, 1956, to May 10, 1956, that I last saw the deceased alive on May 9, 1956, and that death occurred at 6:15 A.M. from the causes and on the date stated above.							
SIGNATURE One for Spruhen M.D. Elkton, Md.				DATE SIGNED May 10, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 13-1956		NAME OF CEMETERY OR CREMATORY North East Methodist Cem		LOCATION (City, town, or county) North East (State) Md.	
24. REC'D BY REGISTRAR DATE 5/14/56		REGISTRAR'S SIGNATURE JH Buzar		25. FUNERAL DIRECTOR'S SIGNATURE Joseph K. Grant		ADDRESS North East, Md.	

2033 CERTIFICATE OF DEATH

FOR ONE YEAR

NEEDS FURNISHED FOR THE DEPARTMENT

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

THE MEDICAL EXAMINATION

DEATH CERTIFICATE

THIS TO

BE

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

DEATH

CERTIFICATE

OF

THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05031

Reg. Dist. No.

5046

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mond	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. LENGTH OF STAY IN 1b 5yrs4mos.14days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 503 Ethan Allen Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EARL Middle M. Last MEINERS		4. DATE OF DEATH Month May Day 27 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Specialist		10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy Dept.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN H. MEINERS		14. MOTHER'S MAIDEN NAME REBECCA SCHMERTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic valve calcification of, and aortic insufficiency DUE TO (c) Arteriosclerotic coronary heart disease, severe		INTERVAL BETWEEN ONSET AND DEATH 24 hours unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, general, severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 13, 19 51, to May 27, 19 56, and that death occurred at 6:20 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 5-28-56	
ACTUAL SIGNATURE W. Oppler M.D.		Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. Oppler, M.D., Director, Professional Services, VAH., Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-28-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON		ADDRESS Havre DeGrace, Md.	
24a. REC'D BY REGISTRAR DATE 5-29-56		24b. REGISTRAR'S SIGNATURE Gene E. Dougherty	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Date of Birth		Sex	
John P. Williams		1915		Male	
Place of Birth		Date of Death		Cause of Death	
Washington, D.C.		1956		Heart Disease	
Occupation		Residence		Manner of Death	
Teacher		1234 Main St.		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	

BUREAU V. 1

MAY 31 1956

RECEIVED

[Handwritten Signature]

MARYLAND STATE DEPARTMENT OF HEALTH

05032

5047

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u> COUNTY <u>Schuylkill</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Earleville</u> LENGTH OF STAY (in this place) <u>24 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Schuylkill Haven</u> <u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Westview Shores</u>		STREET ADDRESS (If rural give location) <u>Hill Farm</u>	
3. NAME OF DECEASED (Type or Print) <u>Wilson</u>	(First) <u>Minick</u> (Middle) <u>Minick</u> (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>May 5 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 1874</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Lebanon Co., Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Jacob Minick</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Bahr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Stanley Schwartz</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>11 hours</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cerebral Arteriosclerosis</u>		<u>years</u>
(c) <u>Generalized Arteriosclerosis</u>		<u>years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 1956, to May 5, 1956, that I last saw the deceased alive on May 5, 1956, and that death occurred at 9:55 p.m., from the causes and on the date stated above.

SIGNATURE Wallace Oshenshaw MD (Degree or title) ADDRESS Cecilston Md 5144 St DATE SIGNED May 5

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 9/56</u>	<u>Centwood Cem.</u>	<u>Pine Grove Rd Pa</u>
DATE REC'D BY LOCAL REG. <u>May 5</u>	REGISTRAR'S SIGNATURE <u>IR Frazer</u>	24. FUNERAL DIRECTOR	ADDRESS <u>Elkton, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G197 5-11-56 et

CERTIFICATE OF DEATH

05033

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 317 Curtis Ave.		d. STREET ADDRESS 317 Curtis Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry E. Moore		4. DATE OF DEATH May 2 Day 1956	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 February 7, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY General Labor	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Moore		14. MOTHER'S MAIDEN NAME Annie Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-9060	
17. INFORMANT 322 North St. Arthur R. Moore Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinoma of Both Lungs DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1956 to May 2, 1956, that I last saw the deceased alive on May 1, 1956, and that death occurred at 4:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Paul J. [Signature] M.D.			
PHYSICIAN'S NAME (Type) 202 E. Main St. Elkton Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-5-1956	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) R. D. Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry [Signature] 2598 Main St. Elkton Md		24a. REC'D BY REGISTRAR DATE 5/5/56	
		24b. REGISTRAR'S SIGNATURE J. H. [Signature]	

BUREAU V. S.

MAY 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0503492
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Seecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>DOA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Lancaster</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quarryville 75x-3</u> d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>Rodger E. Moore</u> First Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1956</u>
9. AGE (In years last birthday) yrs. <u>7</u>		10. AGE (In years last birthday) Months <u>28</u> Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Lancaster Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S C</u>	
13. FATHER'S NAME <u>James E Moore</u>		14. MOTHER'S MAIDEN NAME <u>Kreda Betty Kourleber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>James E Moore Quarryville Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchial</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R C Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R C Dodson</u>		DATE SIGNED <u>5-3-56</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Mar 6/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Offord Pa.</u>		22d. LOCATION (City, town, or county) <u>Offord Chester Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed, Rising Sun</u>		24a. REC'D BY REGISTRAR <u>May 3-56</u>	
24b. REGISTRAR'S SIGNATURE <u>F. Rodary Drayton</u>		24c. REGISTRAR'S SIGNATURE _____	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5926

CERTIFICATE OF DEATH

05035

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN b. 65 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. Middle Edwin Last Naylor		4. DATE OF DEATH Month May Day 2 Year 19 56	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 17, 1884
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forman		10b. KIND OF BUSINESS OR INDUSTRY Textile Mills	
11. BIRTHPLACE (State or foreign country) Blackbird, Del.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Naylor		14. MOTHER'S MAIDEN NAME Saddie F. Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 216-07-5832	
17. INFORMANT Mrs. Elizabeth M. Naylor Elkton, Md.		Address 129 Moffitt St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Esophagus - lower 1/3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Prostate			INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1 , 19 56 , to May 2 , 19 56 , that I last saw the deceased alive on May 2 , 19 56 , and that death occurred at 2:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. RALPH ANDREWS, JR.		ADDRESS (Street, city or town, state) 277 E. Main St. Elkton, Md.	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR. M.D.		DATE SIGNED 5/2/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-6-1956	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo, Pk. R. D. Elkton Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Phipps		24a. REC'D BY REGISTRAR DATE 5/5/56	
ADDRESS 259 E. Main St. Elkton, Md.		24b. REGISTRAR'S SIGNATURE J. H. Phipps	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

STATE OF MARYLAND DEPARTMENT OF HEALTH

BUREAU V. 3

1956

RECEIVED

1. NAME OF DECEASED WILLIAM J. HAYES		2. SEX Male		3. AGE 65	
4. DATE OF DEATH 1956		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Maryland		8. DATE OF BIRTH 1956		9. OCCUPATION Farmer	
10. MARITAL STATUS Married		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF PHYSICIAN	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9, Film 0197 5-11-56 et
5927 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

05036
Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Isent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>				c. LENGTH OF STAY IN 1b <i>18 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gulena</i> <i>14X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>				d. STREET ADDRESS <i>Starkey Farm</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Sofia</i> Middle <i>Olyz</i> Last <i>NYK</i>				4. DATE OF DEATH Month <i>May</i> Day <i>1</i> Year <i>19 56</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>December 28, 1914</i> <i>42</i> yrs.	
9. AGE (In years last birthday) <i>41</i>		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>				12. CITIZEN OF WHAT COUNTRY? <i>DP</i>			
13. FATHER'S NAME <i>Ozian</i>				14. MOTHER'S MAIDEN NAME <i>No Information</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>217-30-9159</i>		17. INFORMANT <i>Stephen Olyz NYK</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive Failure</i> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-Vascular Disease 3 years.</i> DUE TO (c) <i>Chronic glomerulo-nephritis.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>20 minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Hemorrhage and Hypertensive encephalopathy.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>56</i> , to <i>May</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>May 1</i> , 19 <i>56</i> , and that death occurred at <i>11:30</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cecilton, Md</i> DATE SIGNED <i>1 May 56</i>							
ACTUAL SIGNATURE <i>Wallace Obenshain</i> M.D.				PHYSICIAN'S NAME (Type) <i>Wallace Obenshain, M. D.</i> <i>Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 3, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Dennis Catholic Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Lambson Station Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Pippin</i> ADDRESS <i>259 E. Main St. Cecilton 2nd</i>				24a. REC'D BY REGISTRAR <i>5/5/56</i>		24b. REGISTRAR'S SIGNATURE <i>JR Frager</i>	

BUREAU V. S.

155- 8 MAY

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

5028

CERTIFICATE OF DEATH

Reg. Dist. No. *92*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Elkton</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>North East</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Robert J. Peterman</i>				4. DATE OF DEATH (Month) <i>May</i> (Day) <i>27</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 21, 1876</i>		9. AGE last birthday <i>79</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bridge Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>R.R. Ret.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Allen Peterman</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Spence</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>717-09-2659</i>		17. INFORMANT & ADDRESS <i>Ida Peterman North East, Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Rt. Cerebral hemorrhage with left hemiplegia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>42 hrs.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized Arteriosclerosis</i>				<i>10 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				—			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				—			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		—	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>15 Mar 56</i> , 19 <i>56</i> , to <i>27 May</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>26 May</i> , 19 <i>56</i> , and that death occurred at <i>5:55 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Klaus H. Hubner</i> M.D.				ADDRESS (Street, city, town, state) <i>North East Md</i>		DATE SIGNED <i>28 May '56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 31, 56</i>		NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Methodist</i>		LOCATION (City, town, or county) <i>Elkton Rd Cecil, Md</i>	
24. REC'D BY REGISTRAR DATE <i>5/31/56</i>		REGISTRAR'S SIGNATURE <i>J.R. Traeger</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS <i>North East, Md</i>	

CERTIFICATE OF DEATH

4028

See also pp.

1. NAME OF DECEASED

NAME OF DECEASED
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

RACE

HEIGHT

WEIGHT

HAIR

EYES

SKIN

TEETH

NOSE

EARS

NECK

THROAT

VOICE

HEARING

SMELL

TASTE

TOUCH

FEELING

THOUGHT

EMOTION

WILL

CHARACTER

TEMPERAMENT

DISPOSITION

INTELLECT

MEMORY

REASON

IMAGINATION

FAITH

HOPE

CHARITY

LOVE

WISDOM

JUSTICE

MODERATION

TEMPERANCE

VALIANT

LIBERAL

GENEROUS

GRACIOUS

PLACID

QUIET

STABLE

FIXED

IMMOVABLE

UNCHANGING

PERMANENT

LASTING

ENDURING

PERPETUAL

ETERNAL

INFINITE

BOUNDLESS

IMMEASURABLE

INCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

UNIMMEASURABLE

UNINCALCULABLE

UNLIMITED

INEXHAUSTIBLE

UNDEVELOPED

UNEXPLORED

UNDISCOVERED

UNKNOWN

UNFATHOMED

UNPREDICTABLE

UNRELIABLE

UNSTABLE

UNFIXED

UNMOVABLE

UNCHANGEABLE

UNPERMANENT

UNLASTING

UNENDURING

UNPERPETUAL

UNETERNAL

UNINFINITE

UNBOUNDLESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5048
CERTIFICATE OF DEATH

05038
05038
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY 75X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9 mo. 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital		d. STREET ADDRESS R.D. 1	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle B. Last PORTER		4. DATE OF DEATH Month May Day 9 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-7-20
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) West Grove, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Porter		14. MOTHER'S MAIDEN NAME Rhoda Shivery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 161-24-2256	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X Bronchopneumonia due to undetermined cause DUE TO (b) Brain tumor - Recurrent astrocytoma, left DUE TO (c) frontal and temporal regions. (Post-operative) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 8, 1955, to May 9, 1956, and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. 5-9-56 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-9-56	
22c. NAME OF CEMETERY OR CREMATORY New London		22d. LOCATION (City, town, or county) (State) New London, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Foulk Funeral Home, West Grove, Pa.		24a. REC'D BY REGISTRAR DATE May 9/1956	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1-1-1920		1-15-1965		Home		Heart disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of cemetery		20. Name of undertaker	
Teacher		High School		Married		123 Main St.		ABC Corp.		Dr. Smith		St. Mary's		Doe & Sons		Greenwood		Doe & Sons	
21. Name of informant		22. Relationship to deceased		23. Informant's address		24. Informant's phone		25. Informant's occupation		26. Informant's signature		27. Registrar's signature		28. Registrar's title		29. Registrar's address		30. Registrar's phone	
Jane Doe		Wife		456 Elm St.		555-1234		Teacher		[Signature]		[Signature]		Registrar		123 Main St.		555-5678	

BUREAU V. S.

RECEIVED
MAY 11 1966

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5729

CERTIFICATE OF DEATH

05039

Reg. Dist. No. *92*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Eckton</i>		LENGTH OF STAY (in this place) <i>3 hours</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Eckton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>				STREET ADDRESS (If rural give location) <i>P.O. Box 49</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Baby</i>		(Middle)		(Last) <i>Simmons</i>		(Month) (Day) (Year) <i>May 22 1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>5/21/56</i>	9. AGE last birthday Yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min. <i>5</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Eckton Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Robert Alley</i>				14. MOTHER'S MAIDEN NAME <i>Bartara Ann Simmons</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
19c. IMMEDIATE CAUSE (A) <i>Prematurely</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Blower</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Asphyxia due to ligament loss before delivery</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Marginal Placenta previa</i>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>21 May</i>, 19<i>56</i>, to <i>22 May</i>, 19<i>56</i>, that I last saw the deceased alive on <i>21 May</i>, 19<i>56</i>, and that death occurred at <i>5:45 A.M.</i>, from the causes and on the date stated above.							
SIGNATURE <i>George Knudsen</i> M.D.				ADDRESS (Street, city, town, state) <i>Eckton Md</i> DATE SIGNED <i>5/22/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5/24/1956</i>		NAME OF CEMETERY OR CREMATORY <i>Eckton Cemetery</i>		LOCATION (City, town, or county) (State) <i>Eckton, Md.</i>	
24. REC'D BY REGISTRAR DATE <i>5/24/56</i>		REGISTRAR'S SIGNATURE <i>H. J. Frager</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Walter DuBois Jr.</i>		ADDRESS	

2765181XVD

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write)

MARYLAND

JOHN A. JONES

Age

Sex

Color

Married

Single

Widow

Divorced

Never married

Other

Place of birth

Country

State

City

County

Post office

Zip

Occupation

Education

Religion

Political party

Service in armed forces

Service in naval forces

Service in military forces

Service in air force

Service in coast guard

Service in other forces

Service in other services

Service in other departments

Service in other agencies

Service in other organizations

Service in other groups

Service in other associations

Service in other societies

Service in other clubs

Service in other organizations

Service in other groups

Service in other associations

Service in other societies

Service in other clubs

Service in other organizations

BUREAU V. 3

MAY 28 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Spence

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05040

5030 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Cecil	MARYLAND	COUNTY Cecil	STATE MD
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton	LENGTH OF STAY (in this place) 36 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton	STREET ADDRESS (If rural give location) R.D. Providence
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hosp.			
3. NAME OF DECEASED (Type or Print) Sarah		4. DATE OF DEATH (Month) (Day) (Year) May 12 1956	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH Aug 11, 1893	
9. AGE last birthday 62 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 19 56	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm P Kite		14. MOTHER'S MAIDEN NAME Elizabeth Jordan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Robert Stanley Spence Elkton MD			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) Carcinoma of		1954	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION Oct. 1954		19b. MAJOR FINDINGS OF OPERATION Carcinoma of the stomach	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21a. TIME OF INJURY (Month) (Day) (Year) (Hour)		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1955 to May 12, 1956, that I last saw the deceased alive on May 12, 1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
SIGNATURE Richard Spence, D.		ADDRESS (Street, city, town, state) Elkton, MD	
DATE SIGNED May 14, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. DATE THEREOF 5-15-56	
NAME OF CEMETERY OR CREMATORY Sharps		LOCATION (City, town, or county) (State) Elkton, MD	
25. REC'D BY REGISTRAR 5/14/56		26. REGISTRAR'S SIGNATURE R. R. Trager	
27. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Lawrence		ADDRESS Elkton, MD	

3050 CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and medical certification. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

MAY 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5749

CERTIFICATE OF DEATH

Reg. Dist. No. 05041

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge, Md.				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TINA Middle MARCHEL Last STEWART				4. DATE OF DEATH Month May Day 11 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-7-56	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Donald Edward STEWART				14. MOTHER'S MAIDEN NAME Eleanor Cordelia CLARK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INTESTINAL ATRESIONS DUE TO (c) INTESTINAL ATRESIONS INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-7 , 19 56 , to 5-11 , 19 56 , that I last saw the deceased alive on 5-11 , 19 56 , and that death occurred at 0958 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE G. J. O'DONNELL				M.D. U. S. Naval Hospital, Bainbridge, Md. 5/11			
PHYSICIAN'S NAME (Type) G. J. O'DONNELL, LT MC USNR, U. S. NAVAL HOSPITAL, BAINBRIDGE, MD. 5/11/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-56		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		22d. LOCATION (City, town, or county) (State) Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson for Perryville, Md				24a. REC'D BY REGISTRAR DATE 5/11/56		24b. REGISTRAR'S SIGNATURE Dorothy B. Bumble	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CLERGY	
16. SIGNATURE OF NEAREST RELATIVE		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF PROSECUTOR		23. SIGNATURE OF DEFENSE		24. SIGNATURE OF JURY	
25. SIGNATURE OF JUDGE		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

MAY 17 1956

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5050
CERTIFICATE OF DEATH

05042
Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Philadelphia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 9 mo. 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia		d. STREET ADDRESS 7943 Fayette Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle B. Last SYKES		4. DATE OF DEATH Month May Day 16 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-97
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		10b. KIND OF BUSINESS OR INDUSTRY Power Engine Design	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Sykes		14. MOTHER'S MAIDEN NAME Sarah Beaumont	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 160-09-4232	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis, localized & diffuse, due to ruptured peptic ulcer DUE TO (c) Arteriosclerosis, general, severe		INTERVAL BETWEEN ONSET AND DEATH 10-12 days 10 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1 , 19 55 , to May 16 , 19 56 , and that death occurred at 12:05 a. M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 5-16-56	
ACTUAL SIGNATURE W. Oppler		M.D. W. OPPLER	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-16-56	
22c. NAME OF CEMETERY OR CREMATORY Beverly National		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Harold B. Mulligan		ADDRESS 1119 W. Lehigh Ave. Phila. Pa.	
24a. REC'D BY REGISTRAR DATE May 16, 1956		24b. REGISTRAR'S SIGNATURE Gene E. Wanghart	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John J. Smith		Male		45		Jan 15, 1910		Chicago, Ill.	
Cause of Death		Disease		Duration		Time of Day		Place	
Heart Disease		Coronary Artery Disease		10 days		9:00 AM		Home	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
MAY 18 1956
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5931 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Sevier</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elmwood Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Sevier</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bessea Chesapeake City</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Augustus</u> First <u>TATMAN</u> Middle Last 4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1956</u>				5. SEX <u>M.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jun 21 1894</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Boats</u> 11. BIRTHPLACE (State or foreign country) <u>Chesapeake City, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>no information</u> 14. MOTHER'S MAIDEN NAME <u>Eva Tatman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u> 17. INFORMANT <u>Mrs. Felicia Tatman</u> Address <u>Chesapeake City, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>420.1</u> (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R C Dodson</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>R C DODSON MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-11-56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/15/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St Rose's Catholic</u> 22d. LOCATION (City, town, or county) <u>Chesapeake City, Md.</u> (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Hoppin</u> ADDRESS <u>Elkton, Md.</u> 24a. REC'D BY REGISTRAR <u>5/15/56</u> 24b. REGISTRAR'S SIGNATURE <u>FR Frazier</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place execution of this certificate, pending the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 17 1953

RECEIVED
MAY 12 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5951 CERTIFICATE OF DEATH

05044

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Adair</u> Last <u>Price Taylor</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29, 1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Jeremiah Cosden Price</u>			
14. MOTHER'S MAIDEN NAME <u>Arabelle Leach</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Ernest Taylor, Perryville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Liver</u> 156.1 DUE TO _____ Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>November 1, 1955</u> to <u>May 17, 1956</u> that I last saw the deceased alive on <u>May 17, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. Benson</u>				ADDRESS (Street, city or town, state) <u>Port Deposit, Md</u>			
PHYSICIAN'S NAME (Type) <u>C. I. BENSON</u>				DATE SIGNED <u>5-19-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Port Deposit Rural, Md</u>				22e. (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>See a Patterson & Son</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5-19-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Irene E. Daugherty</u>				24c. _____			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUSCRIPT STATEMENT OF HEALTH-EALINGORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5732

CERTIFICATE OF DEATH

05045
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>Chesapeake City</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel R</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1902</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Honey Brook, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willard M. Cornell</u>		14. MOTHER'S MAIDEN NAME <u>May White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Henry Taylor</u> Address <u>R. D. 1 Chesapeake City, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive secondary shock</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u> (b) <u>Acute gastroenteritis</u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>18 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. n. <u> </u> p. m. <u> </u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>56</u> , to <u>5-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-6</u> , 19 <u>56</u> , and that death occurred at <u>5:37</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.		ADDRESS (Street, city or town, state) <u>ELKTON, Md.</u> DATE SIGNED <u>5-6-56</u>	
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>May 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia Memorial Pk.</u>	
22d. LOCATION (City, town, or county) (State) <u>Chester Co. Pa.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Jones</u> ADDRESS <u>Claymont, Del.</u>	
24a. REC'D BY REGISTRAR <u> </u> DATE <u>5/8/56</u>		24b. REGISTRAR'S SIGNATURE <u>JR Frazer</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05046

5052

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		STATE <u>Maryland</u> COUNTY <u>Cecil</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
TOWN <u>Perryville</u>		LENGTH OF STAY (In this place) <u>56 Yrs.</u>		TOWN <u>Perryville</u>		STREET ADDRESS (If rural give location) <u>Aikin Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Aikin Ave.</u>				STREET ADDRESS <u>Aikin Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frank Hopper Walker</u>				<u>May 1 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 10, 1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman, Retired Rail Road</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		<u>U S A</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Crawford Walker</u>				<u>Margaret Sutor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
					<u>Eva B. Walker, Perryville, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				<u>2 years.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hemiplegia left side</u>				<u>1 year.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterio Sclerosis</u>				<u>10 years.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1950</u>, to <u>May 1, 1956</u>, that I last saw the deceased alive on <u>May 1, 1956</u>, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank Wolbert M.D.</u>				ADDRESS (Street, city, town, state) <u>Hanes & Grace Rd - Perryville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE SIGNED <u>May 2 1956</u>			
DATE THEREOF <u>5-4-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Principio</u>		LOCATION (City, town, or county) (State) <u>Principio Furnace, Md.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Irene E. Daugherty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u>			
DATE <u>5-2-56</u>							

CERTIFICATE OF DEATH

2585

NO. 1000

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF BURIAL

16. SIGNATURE OF CREMATION

17. SIGNATURE OF INTERMENT

18. SIGNATURE OF REINTERMENT

19. SIGNATURE OF REINTERMENT

20. SIGNATURE OF REINTERMENT

BUREAU V. S.

MAY 4 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05047

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Becil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elkton Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Becil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Rural</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LESTER</u> First Middle Last <u>Jack Whitman</u>				4. DATE OF DEATH Month Day Year <u>5</u> <u>6</u> <u>1956</u>			
5. SEX <u>M.</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-1903</u>		9. AGE (In years last birthday) <u>53</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H School Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Shinnston W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mortimer Whitman</u>				14. MOTHER'S MAIDEN NAME <u>Betty Schriber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT Address <u>Mrs. Ruth Whitman, Elkton Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R C Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R C Dodson, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>5-7-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>		22d. LOCATION (City, town, or county) (State) <u>Shinnston, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W Henry Tappin</u> Address <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>5/12/56</u>		24b. REGISTRAR'S SIGNATURE <u>FR Fraser</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 15 1956

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

5034

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		LENGTH OF STAY (In this place) <u>4 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
TOWN <u>Union Hospital</u>				TOWN <u>Elkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>107 Csaqest</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Helen Wells Wright</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 31, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 16, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Elkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin M. Wells</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Norman Wright, Elkton, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
570.5 IMMEDIATE CAUSE (A) <u>Hypostatic Pneu monia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Recurrent intestinal obstruction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>intestinal obstruction - adhesions</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>May 15, 1956</u>		19b. MAJOR FINDINGS OF OPERATION. <u>Intestinal Obstruction</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16, 1956</u> , to <u>May 31, 1956</u> , that I last saw the deceased alive on <u>May 31, 1956</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Arthur Penland</u> M.D.				ADDRESS (Street, city, town, state) <u>North East Maryland June 1, 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cem.</u>		LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
24. REC'D BY REGISTRAR <u>6/3/56</u>		REGISTRAR'S SIGNATURE <u>JR Frager</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter du Bose, Jr.</u>		ADDRESS <u>Elkton, Md.</u>	

CERTIFICATE OF DEATH

5034

Reg. No. 10

DATE OF DEATH

DECEASED

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V. S.

JUN 6 1956

RECEIVED

2000000000